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COLANTONI COLLINS LADERA RANCH
SECRET MARQUEZ
855-396-1220 124
MAIL-LR@CCMPT.COM

PROOF OF SERVICE
JONATHAN SHOCKLEY v. BIOTELEMETRY, INC. DBA CARDIONET, LLC
WCAB NO. ADJ12031731

I, Maria Garcia, am over the age of 18 years, and not party to this action. My business address is 555 Corporate Drive, Suite 205, Ladera Ranch, CA 92694.

On, March 31, 2022, I served the following document(s):

- **2022.02.04 - Primary Treating Physician PR-2 - Babak Jamasbi MD:**
- **2022.02.04 - Primary Treating Physician PR-2 - Dr. Babak Jamasbi MD:**
- **2022.03.17 - Med Legal Supplemental Report - Adam J. Stoller MD.**

on the parties listed below:

☐ **BY MAIL:** I am readily familiar with the business practice at my place of business for collection and processing of correspondence for mailing with the United States Postal Service. Correspondence so collected and processed is deposited with the United States Postal Service that same day in the ordinary course of business.

☒ **BY ELECTRONIC SERVICE:** Pursuant to 8 CCR §10625(b)(2) and 8 CCR §10305(i), I served the designated parties listed below by electronic service.

☐ **VIA UPS -** I am readily familiar with the business practice at my place of business for collection and processing of correspondence for shipping via United Parcel Service (UPS). Correspondence so collected and processed is shipped with UPS that same day in the ordinary course of business.

Via Email Only mail@pacificworkers.com
Zachary Kweller, Esq.
Pacific Workers' Compensation Law Center
333 Hegenberger Rd., Ste. 504
Oakland, CA 94621

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on March 31, 2022.

By: Maria Garcia
Maria Garcia

**please note that Declarant's email address is mgarcia@ccmpt.com; however, the firm's email address for service on our Ladera Ranch office is Mail-LR@ccmpt.com.*

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David F. Smolins, M.D.
Mark J. Sontag, M.D.
Elaine S. Date, M.D.
Neeti A. Bathia, M.D.
George J. Rakkar, M.D.
Priyanka E. Ghosh, M.D.

REMEDY MEDICAL GROUP

Adam J. Stoller, M.D.
Alessandra A.E. Ross, M.D.
Mikel Davenport, L.A.c
Marina Zyskina, N.P.
Rachel Brinitzer, N.P.
Joseph Krezanoski, N.P.

www.remedydocs.com

March 17, 2022

MEDICAL LEGAL SUPPLEMENTAL REPORT

RE : SHOCKLEY, Jonathan
DOB : 09/27/78
DOI : 02/15/19 cumulative trauma
CLAIM# : 7173815490
EMP : Cardionet

Dear Concerned Parties,

I am in receipt of a request for a supplemental report on 1/21/22 by Amy Olsen, ESQ regarding Jonathan Shockley. There was one page reviewed. This will be billed as an ML-203.

There is a question regarding my ratings in the March 2021 report for Mr. Shockley, which, I believe, is largely made moot by my subsequent 2/24/22 report. The question was in regard to impairment of the median nerve at the wrist, which in my 2/24/22 exam was determined using 2 point discrmination testing with a filament tester as follows;

When filament testing was done, he has 8 mm of discrimination at his right thumb, 10 mm of discrimination at the base of his left thumb, and 6 mm at the tip of his left thumb.

That was the methodology used that yielded the 50% loss of sensation, which was then multiplied by the maximum sensory impairment to arrive at the 9% UE impairment and 5% WPI for the impairment rating of the hand sensory deficit.

I certify under penalty of perjury I reviewed one page of records as part of the medical legal evaluation and preparation of the report.

I certify that all my opinions are based on a reasonable medical probability unless stated otherwise in the body of this report.

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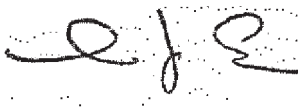
"I certify that I composed and drafted the conclusions of this report. The conclusions and opinions within this report are solely mine. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

In accordance with Labor Code Section 5703(a) (2), there has not been a violation of Labor Code Section 139.3, and the contents of the report are true and correct to the best of my knowledge. I have not offered, delivered, received, or accepted any rebate, refunds, commission, preference, patronage, dividend, discount, or other consideration for any referred examination or evaluation. This statement is made under penalty of perjury. Pursuant to 8 Cal. Code Regulations Section 49.2-49.9, I have complied with the requirement for face-to-face time with the patient in this evaluation/report. I have discussed apportionment in the body of this report, if indicated. If I have assigned disability caused by factors other than the industrial injury, that level of disability constitutes the apportionment. The ratio of nonindustrial disability, if any, to a described disability represents my best medical judgment of the percentage of disability caused by the industrial injury and the percentage of disability caused by other factors, as defined in Labor Code Section 4663 and 4664."

Sincerely,



Adam J. Stoller, M.D.

CC:

Mario Castro, Claims Adjuster
Amy Olson, Defense Attorney
Zachary Kweller, Applicant Attorney

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

1335 Standford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Feb 04, 2022
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 43 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:
***
Patient is presents for an in person follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his

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hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. He is not currently a surgical candidate for the neck. He currently defers injection therapy as well.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR althought he denial has now expired. He has completed 18/18 sessions of chiropractic therapy with benefit. He notes that these sessions helped to decrease his pain by about 30% and noted some improved tolerance for activity. He was approved for 6 more sessions, but he only completed 1/6 so far. His previous chiropractor was no longer able to accept his insurance and he was referred to another provider. This 1 session did not go well however and he awaits a call back from the scheduling agency regarding another referral.

He also trialed physical therapy but was only able to complete 1-2 sessions before his pain increased. He has discontinued this.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

Patient inquires about a generic letter to provide to his landlord today. Apparently he is being asked to move out temporarily from his space for renovations. However, he states that due to his upper extremity pain, this is not possible for him to do. He would like the letter to state that he is not capable of moving out.

Medical History:
***
PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

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Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed..
Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation..
Gait and Station:
No abnormalities observed..
Musculoskeletal - Muscle Tone:
Normal muscle tone without atrophy in right upper extremity.
Normal muscle tone without atrophy in left upper extremity.
Normal muscle tone without atrophy in right lower extremity.
Normal muscle tone without atrophy in left lower extremity..
Skin:
No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily

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2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of acupuncture 97813, 97814, 97026, 97124 Neck Elbow Bilateral Elbows Hand Bilateral Hands Wrist Bilateral Wrists.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1
2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area upt o 4 times daily QTY: 100.00. REF: 1
3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:
***
Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral

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ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient has nearlt completed chiropractic therapy with benefit as described above. He was approved for 6 more but his usual provider is now out of network. He is hoping to hear back from the scheduling agency about alternate options soon. Due to this delay, we will submit once more for acupuncture sessions as the denial has now expired.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to dicuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical canddiate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient currently defers the Functional Restoration Program.

-Patient saw Dr. Stoller again on 3/11/21 and we finally received this report. Per Dr. Stoller, the patient is permanent and stationary with 20% WPI and permanent disability. He did provision for future medical care as well. As patient currently defers FRP or further invasive care, we agree that he is MMI and have updated this below.

-We provided him with a generic letter for his landlord.

Follow up in 4-6 weeks.

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WORK STATUS:
***
The patient is permanent and stationary per Dr. Stoller QME DOS 3/11/21.

TIME SPENT:
For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 30 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified

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case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training

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in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Acupuncture - Cervical Spine: The following has been recommended regarding Acupuncture for the neck in the MTUS/ACOEM guidelines:

Acupuncture is based in part on the theory that many diseases are manifestations of an imbalance between yin and yang, as reflected by disruption of normal vital energy flow (qi) in specific locations, referred to as meridians. Needling along one of the 361 classical acupuncture points on these meridians is believed to restore balance. This stimulation is classically done with thin, solid, metallic needles, which are frequently manipulated (or turned) manually or stimulated electrically (electroacupuncture). In addition to needling, acupuncture frequently involves moxibustion and cupping. Besides traditional Chinese acupuncture, there are many other types of acupuncture that have arisen, including accessing non-traditional acupuncture points.(544, 554, 877-880)

Acupuncture for Chronic Cervicothoracic Pain

Recommended. Acupuncture is recommended for select use in chronic cervicothoracic pain with or without radicular symptoms as an adjunct to facilitate more effective treatments.

Strength of Evidence – Recommended, Evidence (C)

Level of Confidence – Low

Indications: As an adjunct treatment option for chronic cervicothoracic pain as a limited course during which time there are clear objective and functional goals that are to be achieved. Considerations include time-limited use in chronic cervicothoracic pain patients without underlying serious pathology as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. Acupuncture is recommended to assist in increasing functional activity levels more rapidly, and, if it is recommended, the primary attention should remain on the conditioning program. In those not involved in a conditioning program, or who are non-compliant with graded increases in activity levels, this intervention is not recommended.

Benefits: Modest reduction in pain.

Harms: Rare needling of deep tissue, such as artery, lung, etc. and resultant complications. Use of acupuncture may theoretically increase reliance on passive modality(ies) for chronic pain.

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Frequency/Dose/Duration: Different frequencies and numbers of treatments used in quality studies ranged from weekly for 1 month to 20 appointments over 3 months. Usual program is 10 sessions over 3 to 4 weeks.(881) An initial trial of 5 to 6 appointments is recommended in combination with a conditioning program of aerobic and strengthening exercises. Future appointments should be tied to improvements in objective measures to justify an additional 6 sessions, for a total of 12 sessions.

Indications for Discontinuation: Resolution, intolerance, or non-compliance including non-compliance with aerobic and strengthening exercises.

Acupuncture for Acute or Subacute Cervicothoracic Pain

Not Recommended. Routine use of acupuncture is not recommended for treatment of acute or subacute cervicothoracic pain or for acute radicular pain.

Strength of Evidence – Not Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Rationale: There are quality studies evaluating the utility of acupuncture for treatment of chronic cervicothoracic pain, although they conflict to some extent regarding whether it is efficacious and which type of acupuncture to perform. (679, 882-884) One issue is the benefit of acupuncture versus electroacupuncture. A moderate-quality study showed that electroacupuncture was more effective than acupuncture alone.(885) Quality trials compared to sham demonstrated a short term improvement in range of motion and pain(882, 883, 886) and one of these moderate quality trials showed acupuncture was associated with improvements in pain-related activity, sleep, anxiety, depression, and satisfaction with life.(881) Trials comparing acupuncture with no treatment have shown a decrease in pain of up to 40% over baseline after 12 weeks.(887) The highest scored study (see evidence table) showed improvement in motion-related pain 1 hour after acupuncture above that seen for dry needling and sham acupuncture.(882) Benefits beyond the duration of treatment of up to 3 years have been suggested.(881) However, studies generally fail to control for attention bias, and also suggest that needling in locations other than traditional acupuncture points can provide equal benefit,(881, 888, 889) which leads to questions regarding whether it is the needling rather than the acupuncture that was beneficial. Other quality trials have compared acupuncture with physiotherapy and medications and other treatments, with some failing to find differences in outcomes. A moderate-quality study of acupoint electrical stimulation did not find improvement in patients with variable duration of pain ranging from acute to chronic.(890) Other studies found less of an effect or no effect, when compared to other treatments and placebo.(679, 886, 891) One moderate-quality study looked at acupuncture compared to sham acupuncture; both treatment groups improved without a significant difference between the two up to 16 weeks after intervention.(884)

There is no high quality evidence for treatment of acute cervicothoracic pain, radicular pain syndromes, or other cervical pain-related conditions. Acupuncture would not be expected to improve on the history of acute cervicothoracic pain treated with more effective treatments

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reviewed elsewhere.

Despite reservations regarding its true mechanism of action, the overall presence of quality trials demonstrating superiority of acupuncture to sham acupuncture provides quality evidence of efficacy, although the magnitude of benefits is modest and the treatment is passive. Acupuncture is minimally invasive, has relatively low adverse effects in experienced hands, and is moderate cost depending on numbers of treatments.

Evidence: There are 5 high-quality RCTs (679, 882-885) and 42 moderate-quality RCTs or crossover trials (568, 585, 675, 681, 848, 862, 881, 886-920) incorporated into this analysis. There are 5 low-quality RCTs in Appendix 1.(677, 921-924)

A comprehensive literature search was conducted using multiple search engines including PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: acupuncture, acupotomy, electroacupuncture, acupressure, acupuncture therapy, warm needling, dry needling, needling, de-qi, warm, dry, pressure, electric current, needle, pressure needling, cervicalgia, neck, cervical, vertebrae, vertebral, spine, radiculopathy, radiculopathies, radicular, pain, intervertebral disc displacement, herniated, herniat*, displacement, displaced, disc, disk, discs, disks, neck pain, radicular pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review. In PubMed we found and reviewed 223 articles, and considered 49 for inclusion. In Scopus, we found and reviewed 42 articles, and considered 8 for inclusion. In CINAHL, we found and reviewed 8 articles, and considered 2 for inclusion. In Cochrane Library, we found and reviewed 14 articles, and considered 1 for inclusion. We also considered for inclusion 17 articles from other sources. Of the 77 articles considered for inclusion, 51 randomized trials and 21 systematic studies met the inclusion criteria.

Acupuncture - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACOEM Guidelines regarding Acupuncture

Acupuncture
Acupuncture has been used to treat CTS and other hand, wrist, and forearm MSDs.(790, 791) There is evidence of its efficacy for treatment of chronic spine disorders, although the evidence suggests traditional acupuncture is not superior to other acupuncture methods (see Chronic Pain and Low Back Disorders Guidelines).

Acupuncture for Acute, Subacute, or Chronic CTS
Not Recommended. Acupuncture is not recommended for treatment of acute, subacute, or chronic CTS.
Strength of Evidence – Not Recommended, Evidence (C)
Level of Confidence – Low

Rationale: There are quality trials of acupuncture compared with placebo or sham acupuncture and they have failed to show benefit of acupuncture for treatment of CTS.(792) One trial found no differences between acupuncture and oral steroid.(793, 794) Another trial susceptible to

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contact time bias found minimal differences between acupuncture and nocturnal wrist splinting.(781) Thus, the highest quality evidence suggests acupuncture is ineffective for treatment of CTS and acupuncture is not recommended.

Evidence: There are 4 moderate-quality RCTs incorporated into this analysis.(781, 792-794) There are 3 low-quality RCTs in Appendix 2.(795-797)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Acupuncture, Acupuncture Therapy, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random,* randomized, randomization, randomly; systematic, systematic review, retrospective studies, and prospective studies. We found and reviewed 40 articles in PubMed, 411 in Scopus, 83 in CINAHL, 46 in Cochrane Library and 0 in other sources. We considered for inclusion 7 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 9 articles considered for inclusion, 8 randomized trials and 2 systematic studies met the inclusion criteria.

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

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Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOEM guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

Strength of Evidence Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day. Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localize peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine

patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is one high-quality study and moderate-quality studies incorporated into this analysis.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

1335 Standford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Feb 04, 2022
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 43 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:
***
Patient is presents for an in person follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his

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hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. He is not currently a surgical candidate for the neck. He currently defers injection therapy as well.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR althought he denial has now expired. He has completed 18/18 sessions of chiropractic therapy with benefit. He notes that these sessions helped to decrease his pain by about 30% and noted some improved tolerance for activity. He was approved for 6 more sessions, but he only completed 1/6 so far. His previous chiropractor was no longer able to accept his insurance and he was referred to another provider. This 1 session did not go well however and he awaits a call back from the scheduling agency regarding another referral.

He also trialed physical therapy but was only able to complete 1-2 sessions before his pain increased. He has discontinued this.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

Patient inquires about a generic letter to provide to his landlord today. Apparently he is being asked to move out temporarily from his space for renovations. However, he states that due to his upper extremity pain, this is not possible for him to do. He would like the letter to state that he is not capable of moving out.

Medical History:
***
PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

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Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed..
Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation..
Gait and Station:
No abnormalities observed..
Musculoskeletal - Muscle Tone:
Normal muscle tone without atrophy in right upper extremity.
Normal muscle tone without atrophy in left upper extremity.
Normal muscle tone without atrophy in right lower extremity.
Normal muscle tone without atrophy in left lower extremity..
Skin:
No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily

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2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of acupuncture 97813, 97814, 97026, 97124 Neck Elbow Bilateral Elbows Hand Bilateral Hands Wrist Bilateral Wrists.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1
2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area upt o 4 times daily QTY: 100.00. REF: 1
3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:
***
Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral

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ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient has nearlt completed chiropractic therapy with benefit as described above. He was approved for 6 more but his usual provider is now out of network. He is hoping to hear back from the scheduling agency about alternate options soon. Due to this delay, we will submit once more for acupuncture sessions as the denial has now expired.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to dicuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical canddiate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient currently defers the Functional Restoration Program.

-Patient saw Dr. Stoller again on 3/11/21 and we finally received this report. Per Dr. Stoller, the patient is permanent and stationary with 20% WPI and permanent disability. He did provision for future medical care as well. As patient currently defers FRP or further invasive care, we agree that he is MMI and have updated this below.

-We provided him with a generic letter for his landlord.

Follow up in 4-6 weeks.

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WORK STATUS:
***
The patient is permanent and stationary per Dr. Stoller QME DOS 3/11/21.

TIME SPENT:
For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 30 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified

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case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training

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in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Acupuncture - Cervical Spine: The following has been recommended regarding Acupuncture for the neck in the MTUS/ACOEM guidelines:

Acupuncture is based in part on the theory that many diseases are manifestations of an imbalance between yin and yang, as reflected by disruption of normal vital energy flow (qi) in specific locations, referred to as meridians. Needling along one of the 361 classical acupuncture points on these meridians is believed to restore balance. This stimulation is classically done with thin, solid, metallic needles, which are frequently manipulated (or turned) manually or stimulated electrically (electroacupuncture). In addition to needling, acupuncture frequently involves moxibustion and cupping. Besides traditional Chinese acupuncture, there are many other types of acupuncture that have arisen, including accessing non-traditional acupuncture points.(544, 554, 877-880)

Acupuncture for Chronic Cervicothoracic Pain

Recommended. Acupuncture is recommended for select use in chronic cervicothoracic pain with or without radicular symptoms as an adjunct to facilitate more effective treatments.

Strength of Evidence – Recommended, Evidence (C)

Level of Confidence – Low

Indications: As an adjunct treatment option for chronic cervicothoracic pain as a limited course during which time there are clear objective and functional goals that are to be achieved. Considerations include time-limited use in chronic cervicothoracic pain patients without underlying serious pathology as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. Acupuncture is recommended to assist in increasing functional activity levels more rapidly, and, if it is recommended, the primary attention should remain on the conditioning program. In those not involved in a conditioning program, or who are non-compliant with graded increases in activity levels, this intervention is not recommended.

Benefits: Modest reduction in pain.

Harms: Rare needling of deep tissue, such as artery, lung, etc. and resultant complications. Use of acupuncture may theoretically increase reliance on passive modality(ies) for chronic pain.

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Frequency/Dose/Duration: Different frequencies and numbers of treatments used in quality studies ranged from weekly for 1 month to 20 appointments over 3 months. Usual program is 10 sessions over 3 to 4 weeks.(881) An initial trial of 5 to 6 appointments is recommended in combination with a conditioning program of aerobic and strengthening exercises. Future appointments should be tied to improvements in objective measures to justify an additional 6 sessions, for a total of 12 sessions.

Indications for Discontinuation: Resolution, intolerance, or non-compliance including non-compliance with aerobic and strengthening exercises.

Acupuncture for Acute or Subacute Cervicothoracic Pain

Not Recommended. Routine use of acupuncture is not recommended for treatment of acute or subacute cervicothoracic pain or for acute radicular pain.

Strength of Evidence – Not Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Rationale: There are quality studies evaluating the utility of acupuncture for treatment of chronic cervicothoracic pain, although they conflict to some extent regarding whether it is efficacious and which type of acupuncture to perform. (679, 882-884) One issue is the benefit of acupuncture versus electroacupuncture. A moderate-quality study showed that electroacupuncture was more effective than acupuncture alone.(885) Quality trials compared to sham demonstrated a short term improvement in range of motion and pain(882, 883, 886) and one of these moderate quality trials showed acupuncture was associated with improvements in pain-related activity, sleep, anxiety, depression, and satisfaction with life.(881) Trials comparing acupuncture with no treatment have shown a decrease in pain of up to 40% over baseline after 12 weeks.(887) The highest scored study (see evidence table) showed improvement in motion-related pain 1 hour after acupuncture above that seen for dry needling and sham acupuncture.(882) Benefits beyond the duration of treatment of up to 3 years have been suggested.(881) However, studies generally fail to control for attention bias, and also suggest that needling in locations other than traditional acupuncture points can provide equal benefit,(881, 888, 889) which leads to questions regarding whether it is the needling rather than the acupuncture that was beneficial. Other quality trials have compared acupuncture with physiotherapy and medications and other treatments, with some failing to find differences in outcomes. A moderate-quality study of acupoint electrical stimulation did not find improvement in patients with variable duration of pain ranging from acute to chronic.(890) Other studies found less of an effect or no effect, when compared to other treatments and placebo.(679, 886, 891) One moderate-quality study looked at acupuncture compared to sham acupuncture; both treatment groups improved without a significant difference between the two up to 16 weeks after intervention.(884)

There is no high quality evidence for treatment of acute cervicothoracic pain, radicular pain syndromes, or other cervical pain-related conditions. Acupuncture would not be expected to improve on the history of acute cervicothoracic pain treated with more effective treatments

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reviewed elsewhere.

Despite reservations regarding its true mechanism of action, the overall presence of quality trials demonstrating superiority of acupuncture to sham acupuncture provides quality evidence of efficacy, although the magnitude of benefits is modest and the treatment is passive. Acupuncture is minimally invasive, has relatively low adverse effects in experienced hands, and is moderate cost depending on numbers of treatments.

Evidence: There are 5 high-quality RCTs (679, 882-885) and 42 moderate-quality RCTs or crossover trials (568, 585, 675, 681, 848, 862, 881, 886-920) incorporated into this analysis. There are 5 low-quality RCTs in Appendix 1.(677, 921-924)

A comprehensive literature search was conducted using multiple search engines including PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: acupuncture, acupotomy, electroacupuncture, acupressure, acupuncture therapy, warm needling, dry needling, needling, de-qi, warm, dry, pressure, electric current, needle, pressure needling, cervicalgia, neck, cervical, vertebrae, vertebral, spine, radiculopathy, radiculopathies, radicular, pain, intervertebral disc displacement, herniated, herniat*, displacement, displaced, disc, disk, discs, disks, neck pain, radicular pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review. In PubMed we found and reviewed 223 articles, and considered 49 for inclusion. In Scopus, we found and reviewed 42 articles, and considered 8 for inclusion. In CINAHL, we found and reviewed 8 articles, and considered 2 for inclusion. In Cochrane Library, we found and reviewed 14 articles, and considered 1 for inclusion. We also considered for inclusion 17 articles from other sources. Of the 77 articles considered for inclusion, 51 randomized trials and 21 systematic studies met the inclusion criteria.

Acupuncture - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACOEM Guidelines regarding Acupuncture

Acupuncture
Acupuncture has been used to treat CTS and other hand, wrist, and forearm MSDs.(790, 791) There is evidence of its efficacy for treatment of chronic spine disorders, although the evidence suggests traditional acupuncture is not superior to other acupuncture methods (see Chronic Pain and Low Back Disorders Guidelines).

Acupuncture for Acute, Subacute, or Chronic CTS
Not Recommended. Acupuncture is not recommended for treatment of acute, subacute, or chronic CTS.
Strength of Evidence – Not Recommended, Evidence (C)
Level of Confidence – Low

Rationale: There are quality trials of acupuncture compared with placebo or sham acupuncture and they have failed to show benefit of acupuncture for treatment of CTS.(792) One trial found no differences between acupuncture and oral steroid.(793, 794) Another trial susceptible to

contact time bias found minimal differences between acupuncture and nocturnal wrist splinting.(781) Thus, the highest quality evidence suggests acupuncture is ineffective for treatment of CTS and acupuncture is not recommended.

Evidence: There are 4 moderate-quality RCTs incorporated into this analysis.(781, 792-794) There are 3 low-quality RCTs in Appendix 2.(795-797)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Acupuncture, Acupuncture Therapy, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random,* randomized, randomization, randomly; systematic, systematic review, retrospective studies, and prospective studies. We found and reviewed 40 articles in PubMed, 411 in Scopus, 83 in CINAHL, 46 in Cochrane Library and 0 in other sources. We considered for inclusion 7 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 9 articles considered for inclusion, 8 randomized trials and 2 systematic studies met the inclusion criteria.

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOEM guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

Strength of Evidence Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day. Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localize peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine

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patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is one high-quality study and moderate-quality studies incorporated into this analysis.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:

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6 Week(s)

CC:
Kweller, Esq., Zachary : 02/11/2022
Castro, Mario : 02/11/2022
UR, Chubb : 02/11/2022

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 02/10/2022